FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037655

Facility Name: FAIRVIEW NURSING PLAZA INC.

Address: 321 ARNOLD AVE (Number) ROCKFORD (City) 61108 (Zip Code)

County: WINNEBAGO

Telephone Number: (815) 397-5531 **Fax #** (815) 397-7629

IDPA ID Number: 363782675001

Date of Initial License for Current Owners: 09/01/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3	114	Intermediate (ICF)	114	41,610	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,745	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,949	971	924	20,844	8
9	SNF/PED					9
10	ICF	43,936	2,250	442	46,628	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,885	3,221	1,366	67,472	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.79%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 09/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES [X] Date 09/01/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 733

Medicare Intermediary AdminiStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,339	29,179	34,932	245,450		245,450	(20,740)	224,710			1
2	Food Purchase		280,684		280,684	(16,608)	264,077	(134)	263,943			2
3	Housekeeping	185,918	22,146		208,064		208,064	728	208,792			3
4	Laundry	70,767	28,591		99,358		99,358		99,358			4
5	Heat and Other Utilities			117,014	117,014		117,014	2,253	119,267			5
6	Maintenance	52,402	27,855	97,843	178,100		178,100	(25,003)	153,097			6
7	Other (specify):*							3,978	3,978			7
8	**TOTAL General Services**	490,426	388,455	249,789	1,128,670	(16,608)	1,112,063	(38,917)	1,073,145			8
	B. Health Care and Programs											
9	Medical Director			7,300	7,300		7,300		7,300			9
10	Nursing and Medical Records	1,621,772	99,723	347,351	2,068,846		2,068,846	(38,526)	2,030,320			10
10a	Therapy	41,886	5,653	4,612	52,151		52,151		52,151			10a
11	Activities	106,251	11,674	2,688	120,613		120,613		120,613			11
12	Social Services	148,382		7,153	155,535		155,535		155,535			12
13	Nurse Aide Training											13
14	Program Transportation			2,215	2,215		2,215		2,215			14
15	Other (specify):*							4,370	4,370			15
16	**TOTAL Health Care and Programs**	1,918,291	117,050	371,319	2,406,660		2,406,660	(34,156)	2,372,504			16
	C. General Administration											
17	Administrative	118,453		79,056	197,509		197,509	3,225	200,734			17
18	Directors Fees											18
19	Professional Services			174,404	174,404		174,404	(107,676)	66,728			19
20	Dues, Fees, Subscriptions & Promotions			30,338	30,338		30,338	(11,705)	18,633			20
21	Clerical & General Office Expenses	128,627	22,017	40,259	190,903		190,903	39,988	230,891			21
22	Employee Benefits & Payroll Taxes			348,591	348,591	16,608	365,199		365,199			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,589	2,589		2,589	650	3,239			24
25	Other Admin. Staff Transportation			1,841	1,841		1,841	2,735	4,576			25
26	Insurance-Prop.Liab.Malpractice			113,009	113,009		113,009	1,179	114,188			26
27	Other (specify):*							26,199	26,199			27
28	**TOTAL General Administration**	247,080	22,017	790,087	1,059,184	16,608	1,075,792	(45,405)	1,030,387			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,655,797	527,522	1,411,195	4,594,514		4,594,514	(118,479)	4,476,035			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. #0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,731	51,731		51,731	10,025	61,756			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,815	62,815		62,815	4,144	66,959			32
33	Real Estate Taxes			70,494	70,494		70,494	6,111	76,605			33
34	Rent-Facility & Grounds			821,748	821,748		821,748		821,748			34
35	Rent-Equipment & Vehicles			9,291	9,291		9,291	8,017	17,308			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,016,079	1,016,079		1,016,079	28,297	1,044,376			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,225	21,961	68,186		68,186		68,186			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,617	116,617		116,617		116,617			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		46,225	138,578	184,803		184,803		184,803			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,655,797	573,747	2,565,852	5,795,396		5,795,396	(90,181)	5,705,215			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,298	30		9
10	Interest and Other Investment Income	(890)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(134)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,350)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,674)	21		24
25	Fund Raising, Advertising and Promotional	(2,880)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,680)	20		28
29	Other-Attach Schedule	(31,790)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,100)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,081)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (35,081)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (90,181)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

FAIRVIEW NURSING PLAZA INC.

ID# 0037655

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (13,088)	06	1
2	IL Council on LTC - COPE	(3,002)	20	2
3	Trust Fees	(200)	20	3
4	VA Expenses	(8,832)	10	4
5	Theft & Damage	(1,547)	21	5
6	Legal - collections	(85)	19	6
7	Legal - collections	(50)	21	7
8	Prior Year	(3,526)	10	8
9	2002 Seminars adj out in 2001	300	24	9
10	Marketing Expense	(1,840)	20	10
11				11
12				12
13				13
14				14
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16				16
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91				91
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(31,790)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(20,740)							(20,740)	1
2	Food Purchase	(134)											(134)	2
3	Housekeeping			728									728	3
4	Laundry													4
5	Heat and Other Utilities			915	1,338								2,253	5
6	Maintenance	(13,088)		646	(12,515)	(46)							(25,003)	6
7	Other (specify):*				1,016	2,962							3,978	7
8	**TOTAL General Services**	(13,221)		2,289	(10,161)	(17,824)							(38,917)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,358)			(21,102)			(5,067)					(38,526)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				4,370								4,370	15
16	**TOTAL Health Care and Programs**	(12,358)			(16,732)			(5,067)					(34,156)	16
	C. General Administration													
17	Administrative			16,843	(65,587)	52,412			(443)				3,225	17
18	Directors Fees													18
19	Professional Services	(85)		(101,820)	(12,178)	6,400			7				(107,676)	19
20	Fees, Subscriptions & Promotions	(11,953)		225	19				4				(11,705)	20
21	Clerical & General Office Expenses	(21,272)		56,349	4,878				33				39,988	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	380		45	225								650	24
25	Other Admin. Staff Transportation			661	2,074								2,735	25
26	Insurance-Prop.Liab.Malpractice			494	685								1,179	26
27	Other (specify):*			10,925	6,012	9,182			80				26,199	27
28	**TOTAL General Administration**	(32,930)		(16,278)	(63,872)	67,994			(319)				(45,405)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(58,509)		(13,989)	(90,765)	50,170		(5,067)	(319)				(118,479)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,298		2,401	3,326								10,025	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(890)		1,221	3,813								4,144	32
33	Real Estate Taxes			2,163	3,948								6,111	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			3,271	4,746								8,017	35
36	Other (specify):*													36
37	**TOTAL Ownership**	3,408		9,056	15,833								28,297	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(55,100)		(4,933)	(74,932)	50,170		(5,067)	(319)				(90,181)	45

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 728	$ 728	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	915	915	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	646	646	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,843	16,843	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,610	2,610	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	225	225	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	56,349	56,349	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	45	45	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	661	661	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	494	494	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	10,925	10,925	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,401	2,401	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,221	1,221	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,163	2,163	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,271	3,271	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	104,430	PREFERRED BOOKKEEPING	100.00%		(104,430)	32
33	V	19	COMPUTER	5,112	PREFERRED BOOKKEEPING	100.00%	5,112		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 109,542			$ 104,609	$ * (4,933)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,338	$ 1,338	15
16	V	6	REPAIRS AND MAINT.	19,176	S.I.R. MANAGEMENT, INC.	100.00%	6,661	(12,515)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,016	1,016	17
18	V	10	NURSING	42,180	S.I.R. MANAGEMENT, INC.	100.00%	21,078	(21,102)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,370	4,370	19
20	V	17	ADMINISTRATIVE	74,736	S.I.R. MANAGEMENT, INC.	100.00%	9,149	(65,587)	20
21	V	19	PROFESSIONAL FEES	17,256	S.I.R. MANAGEMENT, INC.	100.00%	5,078	(12,178)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	19	19	22
23	V	21	CLERICAL & GENERAL	21,732	S.I.R. MANAGEMENT, INC.	100.00%	26,610	4,878	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	225	225	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,074	2,074	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	685	685	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,012	6,012	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,326	3,326	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,813	3,813	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,948	3,948	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,746	4,746	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 175,080			$ 100,148	$ * (74,932)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 21,732	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,660	$ (15,072)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,381	1,381	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	41,739	41,739	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	14,068	14,068	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,123	7,123	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	7,445	7,445	21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,195	1,195	22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	5,747	5,747	24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	864	864	25
26	V								26
27	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V								29
30	V	6	REPAIRS AND MAINT.	144	S.I.R. MANAGEMENT, INC.	100.00%	98	(46)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	20	20	31
32	V								32
33	V	1	DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	7,532	(5,668)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,561	1,561	34
35	V								35
36	V	19	LEGAL FEES	7,668	S.I.R. MANAGEMENT, INC.	100.00%		(7,668)	36
37	V								37
38	V	17	COUNCIL DUES	2,520	S.I.R. MANAGEMENT, INC.	100.00%		(2,520)	38
39	Total			$ 45,264			$ 95,434	$ * 50,170	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 123,044	$ 123,044	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	123,044	CCS EMPLOYEE BENEFIT GROUP	100.00%		(123,044)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 123,044			$ 123,044	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	XCEL Medical Supply, LLC	100.00%	$	$	15
16	V	03	Housekeeping		XCEL Medical Supply, LLC	100.00%			16
17	V	10	Nursing	37,403	XCEL Medical Supply, LLC	100.00%	32,336	(5,067)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,403			$ 32,336	$ * (5,067)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 7	$ 7	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	4	4	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	33	33	17
18	V	17	MANAGEMENT FEES	1,800	ECM OWNERS COUNCIL	100.00%		(1,800)	18
19	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	1,357	1,357	19
20	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	80	80	20
21	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,800			$ 1,481	$ * (319)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish		Administrative		See Attached	1.57	4.49%	alloc sal	$ 7,445	17-7	1
2	Louise Bergthold	Owner	Administrative	2.63%	See Attached	5.91	10.75%	alloc sal	19,126	17-7	2
3	Mike Giannini		Administrative		See Attached	1.79	4.48%	alloc sal	7,105	17-7	3
4	Tom Winter	Owner	Administrative	0.88%	See Attached	6.68	11.13%	alloc sal	16,843	17-7	4
5	Arturo Rominiquit	Relative	Courier	0%	See Attached	4.08	11.13%	alloc sal	2,633	21-7	5
6	Nenita Guzman	Relative	Dietary	0%	See Attached	5.37	10.74%	alloc sal	6,660	1-7	6
7	Mark Solomon	Owner	Administrator	6.58%	None	40	100.00%	salary	88,656	17-1	7
8	Eric Rothner	Relative	Administrative		See Attached	0.68	0.94%	alloc sal	1,893	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 150,361		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	938,058	11	$ 6,541	$	104,430	$ 728	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	938,058	11	8,219		104,430	915	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	938,058	11	5,799		104,430	646	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	938,058	11	151,295	151,295	104,430	16,843	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	938,058	11	23,448		104,430	2,610	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	938,058	11	2,020		104,430	225	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	938,058	11	506,159	442,988	104,430	56,349	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	938,058	11	400		104,430	45	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	938,058	11	5,937		104,430	661	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	938,058	11	4,435		104,430	494	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	938,058	11	98,137		104,430	10,925	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	938,058	11	21,566		104,430	2,401	12
13	32	INTEREST	BOOK./ACCNT.INCOME	938,058	11	10,965		104,430	1,221	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	938,058	11	19,425		104,430	2,163	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	938,058	11	29,379		104,430	3,271	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,112	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 893,725	$ 594,283		$ 104,609	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	628,177	10	$ 12,461	$	67,472	$ 1,338	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	628,177	10	62,016	45,622	67,472	6,661	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	628,177	10	9,458		67,472	1,016	3
4	10	NURSING	PATIENT DAYS	628,177	10	196,243	196,243	67,472	21,078	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	628,177	10	40,682		67,472	4,370	5
6	17	ADMINISTRATIVE	PATIENT DAYS	628,177	10	85,174	85,174	67,472	9,149	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	628,177	10	47,273		67,472	5,078	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	628,177	10	176		67,472	19	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	628,177	10	247,745	202,804	67,472	26,610	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	628,177	10	2,093		67,472	225	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	628,177	10	19,306		67,472	2,074	11
12	26	INSURANCE	PATIENT DAYS	628,177	10	6,377		67,472	685	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	628,177	10	55,976		67,472	6,012	13
14	30	DEPRECIATION	PATIENT DAYS	628,177	10	30,963		67,472	3,326	14
15	32	INTEREST	PATIENT DAYS	628,177	10	35,501		67,472	3,813	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	628,177	10	36,759		67,472	3,948	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	628,177	10	44,185		67,472	4,746	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 932,388	$ 529,843		$ 100,148	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	628,177	10	$ 62,004	$ 62,004	67,472	$ 6,660	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	628,177	10	12,854		67,472	1,381	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	628,177	10	388,593	388,593	67,472	41,739	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	628,177	10	130,972		67,472	14,068	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	628,177	10	$ 66,321	$	67,472	$ 7,123	5
6										6
7	17	ADMIN. SALARY	AVG HRS WKD	35	10	165,979	165,979	2	7,445	7
8	27	EMP. BEN.-ADMIN.	AVG HRS WKD	35	10	26,644		2	1,195	8
9						$	$		$	9
10	17	ADMIN SALARY	AVG HRS WKD	40	10	128,429	128,429	2	5,747	10
11	27	EMP. BEN.-ADMIN.	AVG HRS WKD	40	10	19,310		2	864	11
12										12
13	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	$ 60,726	$ 60,726		$	13
14	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	12,589				14
15										15
16	6	REPAIRS AND MAINT.	MAINTENANCE INC.	177,156	10	120,809	120,809	144	98	16
17	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	177,156	10	25,044		144	20	17
18										18
19	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	71,551	71,551	13,200	7,532	19
20	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	14,833		13,200	1,561	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,306,658	$ 998,091		$ 95,434	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 123,044	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 123,044	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)3287615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$	1
2	03	Housekeeping	Direct Allocation							2
3	10	Nursing	Direct Allocation						32,336	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 32,336	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	40,000	9	$ 150	$	1,800	$ 7	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	40,000	9	89		1,800	4	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	40,000	9	739		1,800	33	3
4	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	40,000	9			1,800		4
5	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	38	9	29,045	29,045	2	1,357	5
6	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	38	9	1,713		2	80	6
7	17	ADMIN. SALARY	DIRECT ALLOCATION		7	(2,635)				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 29,101	$ 29,045		$ 1,481	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	SIR	X		Line of Credit				1,390,000		4.25%	59,304	6
7	Insurance		X								3,511	7
8												8
9	TOTAL Facility Related						$	$ 1,390,000			$ 62,815	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										4,144	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,144	14
15	TOTALS (line 9+line14)						$	$ 1,390,000			$ 66,960	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (890)	1
2	Allocated from Preferred	X									1,221	2
3	Allocated from SIR	X									3,813	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,144	21

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	104,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	92,205	2
3. Under or (over) accrual (line 2 minus line 1).	$	(12,195)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	76,605	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	102,255	8
1998	103,278	9
1999	102,486	10
2000	101,225	11
2001	86,094	12

2002 Accrual = 86,094 x 1.03 = 88,800

Preferred Bookkeeping Allocation $2163

SIR Management Allocation $3948

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRVIEW NURSING PLAZA INC. COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-28-203-004	Long term Care Property	$ 86,094.00	$ 86,094.00
2.	See attached	SIR Management Allocation	$ 32,006.79	$ 3,437.82
3.	See attached	Preferred Bookkeeping Allocation	$ 16,913.82	$ 1,882.94
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 135,014.61	$ 91,414.76

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRVIEW NURSING PLAZA INC. COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0037655

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,808 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1992	55,434		20	2,772	2,772	29,317	9
10	Various			1993	68,424		20	3,421	3,421	32,031	10
11	Various			1994	44,837		20	2,242	2,242	19,850	11
12	Various			1995	14,482		20	724	724	5,125	12
13	Various			1996	7,472		20	374	374	2,439	13
14	Various			1997	73,164		20	3,658	3,658	20,600	14
15	Various			1998	18,987		20	948	948	3,593	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		89,795	3,203		3,542	339	26,638	68
69	Financial Statement Depreciation			6,490			(6,490)		69
70	TOTAL (lines 4 thru 69)		$ 372,595	$ 9,693		$ 17,681	$ 7,988	$ 139,593	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 372,595	$ 9,693		$ 17,681	$ 7,988	$ 139,593	1
2	ELEVATOR REPAIR	1999	8,463		20	423	423	1,657	2
3	COUNTER TOPS	1999	4,880		20	488	488	2,399	3
4	HVAC-HEAT EXCHANGES	1999	4,000		20	200	200	800	4
5	HVAC-HEAT EXCHANGER	1999	4,100		20	205	205	752	5
6	WATER HEATER	1999	8,709		20	435	435	1,523	6
7	ELEVATOR WORK	1999	4,002		20	200	200	683	7
8	SIR REMODELING	1999	11,917		20	596	596	1,937	8
9	ELEVATOR WORK	1999	2,962		20	148	148	493	9
10	HVAC EXCHANGER	1999	3,875		20	194	194	614	10
11	ROOM DIVIDERS	1999	6,841		20	342	342	1,083	11
12	HVAC EXCHANGER	1999	3,731		20	187	187	592	12
13	WATER SOFTNER	1999	2,000		20	200	200	1,217	13
14	WATER HEATER	2000	4,598		20	230	230	671	14
15	HEAT EXCHANGER	2000	1,145		20	57	57	166	15
16	PAINTING	2000	16,100		20	805	805	1,878	16
17	WINDOW TREATMENT	2000	2,904		20	145	145	387	17
18	PAINTING	2000	10,000		20	500	500	1,042	18
19	HEAT EXCHANGER	2000	3,940		20	197	197	410	19
20	HANDRAILS	2000	8,261		20	413	413	826	20
21	PAINTING	2001	4,000		20	200	200	400	21
22	PAINTING	2001	7,000		20	350	350	671	22
23	ELEVATOR WORK	2001	11,945		20	597	597	1,144	23
24	HVAC WORK	2001	4,148		20	207	207	328	24
25	WATER HEATER	2001	9,438		20	472	472	590	25
26	CARPETING	2001	3,845		20	192	192	224	26
27	FREEZER COMPRESSOR	2001	2,101		20	105	105	210	27
28	FREEZER WORK	2001	1,561		20	78	78	143	28
29	HEATER REPAIR	2001	2,207		20	110	110	119	29
30	PATIO LIGHT	2001	1,302		20	65	65	81	30
31	DOOR REPLACEMENT	2002	2,298		20	306	306	306	31
32	MINI BLINDS	2002	1,014		20	59	59	59	32
33	HVAC	2002	20,225		20	169	169	169	33
34	TOTAL (lines 1 thru 33)		$ 556,107	$ 9,693		$ 26,556	$ 16,863	$ 163,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 556,107	$ 9,693		$ 26,556	$ 16,863	$ 163,167	1
2	WATER HEATER	2002	4,993		20	458	458	458	2
3	GREAST TRAP	2002	3,181		20	53	53	53	3
4	ROOF	2002	800		20	40	40	40	4
5	DRYWALL	2002	3,150		20	158	158	158	5
6	STOREROOM DOOR	2002	1,168		20	58	58	58	6
7	SIDEWALK/LANDSCAPING	2002	1,675		20	84	84	84	7
8	NURSES STATION COUNTER	2002	610		20	31	31	31	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 571,684	$ 9,693		$ 27,438	$ 17,745	$ 164,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5				1993	28,701	911	35	820	(91)	7,790	5
6				1993	15,720	499	35	449	(50)	4,267	6
7											7
8											8
	Improvement Type**										
9	Allocated from Preferred Bookkeeping			1997	19,632	440	20	982	542	5,702	9
10	Allocated from Preferred Bookkeeping			1999	156	-	20	8	8	27	10
11	Allocated from Preferred Bookkeeping			2000	985	-	20	49	49	119	11
12											12
13	Allocated from SIR Management			1993	12,327	343	20	622	279	6,102	13
14	Allocated from SIR Management			1994	40	-	20	4	4	32	14
15	Allocated from SIR Management			1995	282	-	20	14	14	104	15
16	Allocated from SIR Management			1999	1,339	45	20	67	22	215	16
17	Allocated from SIR Management			2000	808	85	20	40	(45)	109	17
18											18
19	Allocated from SIR Properties - SIR Management			2002	114	-	20	3	3	3	19
20	Allocated from SIR Properties - SIR Management			1999	3,637	364	20	182	(182)	636	20
21	Allocated from SIR Properties - SIR Management			1998	1,738	174	20	87	(87)	391	21
22	Allocated from SIR Properties - SIR Management			1997	108	11	20	5	(6)	35	22
23	Allocated from SIR Properties - SIR Management			1994	273	7	20	14	7	116	23
24	Allocated from SIR Properties - SIR Management			1993	465	13	20	23	10	221	24
25											25
26	Allocated from SIR Properties - Preferred Bookkeeping			2002	62	-	20	2	2	2	26
27	Allocated from SIR Properties - Preferred Bookkeeping			1999	1,992	199	20	100	(99)	349	27
28	Allocated from SIR Properties - Preferred Bookkeeping			1998	952	95	20	48	(47)	214	28
29	Allocated from SIR Properties - Preferred Bookkeeping			1997	59	6	20	3	(3)	19	29
30	Allocated from SIR Properties - Preferred Bookkeeping			1994	150	4	20	7	3	64	30
31	Allocated from SIR Properties - Preferred Bookkeeping			1993	255	7	20	13	6	121	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 89,795	$ 3,203		$ 3,542	$ 339	$ 26,638	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 377,240	$ 47,765	$ 33,296	$ (14,469)	10	$ 240,688	71
72	Current Year Purchases	11,354		1,022	1,022	10	1,128	72
73	Fully Depreciated Assets	49,183				10	49,183	73
74								74
75	TOTALS	$ 437,777	$ 47,765	$ 34,318	$ (13,447)		$ 290,999	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	CHEVY VAN	1996	$ 11,516	$	$	$	5	$ 11,516	76
77										77
78										78
79										79
80	TOTALS			$ 11,516	$	$	$		$ 11,516	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,020,977	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,458	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,756	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,298	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 466,564	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: First Chicago Trust Co of Illinois

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		213		$ 821,748			3
4	Additions							4
5								5
6								6
7	TOTAL		213		$ 821,748 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 02/1996
Ending 09/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 861,674
13.	/2004	$ 874,631
14.	/2005	$ 874,631

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 17,308 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 8,684	$		$ 8,684	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			121			121	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			13,156			13,156	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				24,648		24,648	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						21,577		21,577	13
14	TOTAL			$		$ 21,961	$ 46,225		$ 68,186	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 25,429	$	1
2	Cash-Patient Deposits	34,679		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,091,360		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,976		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	79,763		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,247,207	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	234,809		15
16	Equipment, at Historical Cost	523,952		16
17	Accumulated Depreciation (book methods)	(494,385)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 264,376	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,511,583	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 212,635	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,128		28
29	Short-Term Notes Payable	1,390,000		29
30	Accrued Salaries Payable	208,347		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,156		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,800		32
33	Accrued Interest Payable	1,555		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	59,132		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,016,753	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,016,753	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (505,170)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,511,583	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (387,085)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (387,085)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(118,085)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (118,085)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (505,170)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,565,763	1
2	Discounts and Allowances for all Levels	6,172	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,571,935	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,893	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 60,893	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,597	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	975	19
20	Radiology and X-Ray	724	20
21	Other Medical Services	4,022	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 29,318	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	890	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 890	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	14,275	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,275	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,677,311	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,128,670	31
32	Health Care	2,406,660	32
33	General Administration	1,059,184	33
	B. Capital Expense		
34	Ownership	1,016,079	34
	C. Ancillary Expense		
35	Special Cost Centers	68,186	35
36	Provider Participation Fee	116,617	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,795,396	40
41	**Income before Income Taxes (line 30 minus line 40)****	(118,085)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (118,085)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,079	2,149	$ 64,009	$ 29.79	1
2	Assistant Director of Nursing	1,446	1,503	35,791	23.82	2
3	Registered Nurses	6,892	7,221	124,056	17.18	3
4	Licensed Practical Nurses	26,044	28,479	562,796	19.76	4
5	Nurse Aides & Orderlies	74,819	80,273	791,466	9.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,104	3,290	41,886	12.73	8
9	Activity Director	1,961	2,089	25,167	12.05	9
10	Activity Assistants	8,226	9,181	81,084	8.83	10
11	Social Service Workers	13,607	14,240	148,382	10.42	11
12	Dietician					12
13	Food Service Supervisor	2,593	2,827	34,139	12.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,565	21,415	147,200	6.87	15
16	Dishwashers					16
17	Maintenance Workers	3,912	4,548	52,402	11.52	17
18	Housekeepers	23,366	25,185	185,918	7.38	18
19	Laundry	7,985	8,669	70,767	8.16	19
20	Administrator	1,949	2,086	88,656	42.51	20
21	Assistant Administrator	1,759	1,937	29,797	15.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,496	10,063	128,627	12.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,861	3,163	43,654	13.80	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	212,663	228,317	$ 2,655,797 *	$ 11.63	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 13,200	01-03	35
36	Medical Director	Monthly	7,300	09-03	36
37	Medical Records Consultant	12	600	10-03	37
38	Nurse Consultant	Monthly	42,180	10-03	38
39	Pharmacist Consultant	Monthly	1,147	10-03	39
40	Physical Therapy Consultant	74	3,874	10a-03	40
41	Occupational Therapy Consultant	14	738	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	2,688	11-03	44
45	Social Service Consultant	88	4,653	12-03	45
46	Other(specify)				46
47	Psychiatric MC consult	Monthly	2,500	12-03	47
48	Director of Food Services	Monthly	21,732	01-03	48
49	TOTAL (lines 35 - 48)	242	$ 100,612		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,124	$ 145,159	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	8,886	158,265	10-03	52
53	TOTAL (lines 50 - 52)	13,011	$ 303,424		53

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Solomon	Administrator	6.58%	$ 88,656
Rebecca Riedstra	Asst Admin	0	29,797
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,452

B. Administrative - Other

Description	Amount
S.I.R. Management, Inc. - Ancillary Admin. Charges	$ 47,892
S.I.R. Management, Inc. - Director of Admin Services	26,844
Owners Council Dues-Extended Care Mgmt	4,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 79,056
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Preferred Bookkeeping	Accounting	$ 27,750
Frost Ruttenberg & Rothblatt	Accounting	16,375
Personell Planners	Unemployment Consultant	2,130
Preferred Bookkeeping	Computer Consultant	5,112
Preferred Bookkeeping	Bookkeeping	76,680
ProClaim	3rd party ins setup fee	271
Michael Best & Friedrich	Legal	19,592
S.I.R. Mgmt	Regulatory Consultant	17,256
SIR Management, Inc	Legal	7,668
IOC Solutions	Computer Support	165
LTC Solutions	Computer Support	1,320
Forest	Legal collec; adj out pg 5	85
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 174,404

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,934
Unemployment Compensation Insurance	33,739
FICA Taxes	198,094
Employee Health Insurance	84,123
Employee Meals	16,608
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	2,228
Employee Benefits	13,472
TOTAL (agree to Schedule V, line 22, col.8)	$ 365,198

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	9,330
Health Care Worker Background Check	732
(Indicate # of checks performed 105)	
IL Council on LTC	6,832
Dues & Subscriptions	707
Advertising & Promotion, Yellow Pages	5,560
Licenses & Permits	385
Allocated from Pref Bkpng	225
Allocated from SIR Mgmt	19
Less: Public Relations Expense	( )
Non-allowable advertising	(2,880)
Yellow page advertising	(2,680)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,630

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,588
Allocated from Pref Bkpng	45
Allocated from SIR Mgmt	225
2002 seminars adj out in 2001	380
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,238

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FAIRVIEW NURSING PLAZA INC. # 0037655 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $9834**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,849** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **116,617**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,608** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day traini no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees